

Centers for Medicare & Medicaid Services, HHS

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calculated using the formula—Withhold % = -0.75 (Bonus %) + 25%.

(v) Capitation arrangements, if—

(A) The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments;

(B) The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

(vi) Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

(e) *Prohibition for private MA fee-for-service plans.* An MA fee-for-service plan may not operate a physician incentive plan.

(f) *Stop-loss protection requirements—*(1) *Basic rule.* The MA organization must assure that all physicians and physician groups at substantial finan-

cial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

(2) *Specific requirements.* (i) Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

(ii) For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph (g) of this section.

(iii) Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel size	Single combined deductible	Separate institutional deductible	Separate professional deductible
1–1,000	\$6,000	\$10,000	\$3,000
1,001–5,000	30,000	40,000	10,000
5,001–8,000	40,000	60,000	15,000
8,001–10,000	75,000	100,000	20,000
10,001–25,000	150,000	200,000	25,000
>25,000	(¹)	(¹)	(¹)

¹ None.

(g) *Pooling of patients.* Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several MA organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

(1) It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group.

(2) The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled.

(3) The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled.

(4) The distribution of payments to physicians from the risk pool is not

calculated separately by patient category.

(5) The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

(h) *Sanctions.* An MA organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

§ 422.210 Assurances to CMS.

(a) Assurances to CMS. Each organization will provide assurance satisfactory to the Secretary that the requirements of § 422.208 are met.

(b) Disclosure to Medicare Beneficiaries. Each MA organization must provide the following information to

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any Medicare beneficiary who requests it:

(1) Whether the MA organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

[70 FR 52026, Sept. 1, 2005]

§ 422.212 Limitations on provider indemnification.

An MA organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the MA organization's denial of medically necessary care:

(a) A physician or health care professional.

(b) Provider of services.

(c) Other entity providing health care services.

(d) Group of such professionals, providers, or entities.

§ 422.214 Special rules for services furnished by noncontract providers.

(a) *Services furnished by non-section 1861(u) providers.* (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

(2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

(b) *Services furnished by section 1861(u) providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an

MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

(c) *Deemed request for Medicare payment rate.* A noncontract section 1861(u) of the Act provider of services that furnishes services to MA enrollees and submits the same information that it would submit for payment under Original Medicare is deemed to be seeking to be paid the amount it would be paid under Original Medicare unless the provider expressly notifies the MA organization in writing that it is billing an amount less than such amount.

(d) *Regional PPO payments in non-network areas.* An MA Regional PPO must pay non-contract providers the Original Medicare payment rate in those portions of its service area where it is providing access to services by non-network means under § 422.111(b)(3)(ii) of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 47490, Aug. 12, 2005; 76 FR 21564, Apr. 15, 2011]

§ 422.216 Special rules for MA private fee-for-service plans.

(a) *Payment to providers—(1) Payment rate.* (i) The MA organization must establish payment rates for plan covered items and services that apply to deemed providers. The MA organization may vary payment rates for providers in accordance with § 422.4(a)(3).

(ii) Providers must be reimbursed on a fee-for-service basis.

(iii) The MA organization must make information on its payment rates available to providers that furnish services that may be covered under the MA private fee-for-service plan.

(2) *Noncontract providers.* The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).